**Department of Community Medicine**

**PRACTICAL NOTE BOOK**

**● Day Visits Reports**

**Batch : SWMC – V**

**Reg. No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Session: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Code No.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Sylhet Women’s Medical college**

**Mirboxtula, Sylhet**

**REPORT ON DAY VISITS**

* **CHEST DISEASE HOSPITAL, SYLHET**
* **LEPROSY HOSPITAL, SYLHET**
* **JALALABAD DISABLED REHABILITATION CENTRE & HOSPITAL, SYLHET**

# CHEST DISEASE HOSPITAL

We the 4th year MBBS students(SWMC-III) of Sylhet Women’s Medical College have visited Sylhet Chest Disease Hospital on11th & 12th March, 2011 under the guidance of department of Community Medicine. Chest disease hospital, Sylhet is a specialized hospital in Sylhet Sadar at Shahi Eidgah situated in between shahi Eidgah and MC College i.e to the east of Shahi Eidgah and to the west of MC College. The hospital was established in the year of 1952 with the objective to provide treatment of tubercular and non-tubercular chest diseases. Initially it was established only to treat the tubercular disease, later its service was extended to include other non-tubercular chest diseases. There are two separate buildings; one for indoor services and another for outdoor services and diagnostic services. The hospital is headed by Senior consultant, Dr.Monirul Islam.

**Date of visit :** 11.03.2011 & 12-03-2011

**Name of organization : Chest Disease Hospital, Sylhet**

**Location :** East Shahi Eidgah, Sylhet

**Year of establishment :** 1952

**Objectives of visiting Chest Disease Hospital:**

1. To see the service rendered by Chest Disease Hospital.
2. To see the management of cases of tubercular and non-tubercular chest disease and the system they have adopted for different types of those cases.
3. To see some cases of tuberculosis which are infrequent in general hospitals.
4. Staffing pattern & infrastructure of the hospital.
5. Protective measure of the employee, if any.

**Infrastructure:**

The hospital has a land area of 330 Bighas.

It has two separate buildings- One for indoor service and the other for outdoor &

diagnostic services.

**Indoor service**: Number of beds: 100

Bed occupied on the day of visit: 46 (Male: 35, Female: 11)

**Outdoor service: A**bout 40 patients attending at the Out Patient Department daily on

an average.

**Activities of organization:**

1. To ensure effective chemotherapy to all patients free of cost.
2. Promotion of early detection of sputum positive tuberculosis cases.

**Staffing of the Hospital:**

|  |  |  |
| --- | --- | --- |
|  | **Name of the post** | **Number of post** |
|  | Senior consultant | 1 |
|  | Medical officer | 4 |
|  | Senior stuff nurse | 12 |
|  | Stuff nurse | 4 |
|  | Medical technologists | |
|  | Pathology department | 1 |
| Pharmacy department | 1 |
| Radiology department | 1 |

### Personal observation:

On visit my observation are as follows-

1. It is 100-bedded hospital but all beds are occupied with patients.
2. Cleanness of hospital is average.
3. Working environment is satisfactory.
4. Lack of manpower.

Disease review: Tuberculosis

**Tuberculosis** or **TB** (short for Tubercle [Bacillus](http://en.wikipedia.org/wiki/Bacillus_(shape))) is a common and often deadly [infectious disease](http://en.wikipedia.org/wiki/Infectious_disease) caused by [mycobacteria](http://en.wikipedia.org/wiki/Mycobacterium), usually [*Mycobacterium tuberculosis*](http://en.wikipedia.org/wiki/Mycobacterium_tuberculosis) in humans. Tuberculosis usually attacks the [lungs](http://en.wikipedia.org/wiki/Lung) but can also affect other parts of the body. It is spread through the air, when people who have the disease cough, sneeze, or spit. Most infections in humans result in an [asymptomatic](http://en.wikipedia.org/wiki/Asymptomatic), latent infection, and about one in ten latent infections eventually progresses to active disease, which, if left untreated, kills more than 50% of its victims.

* **Global scenario :** With 1.7 million deaths, 9.2 million new active cases per year

and nearly two billion people harboring latent infection.

* **Bangladesh scenario :** In 2006, Bangladesh ranked 6th on the list of 22 highest TB countries in the world. According to WHO, in 2006, apx. 391 cases per 100,000 population. Of these, apx. 101 per 100,000 were infectious cases.
* **Estimated Incidence rate :** Sputum +ve :101/1,00,000/yeaqr
* **Estimated Prevalence rate :**  391/1,00,000 population
* **Estimated mortality :** 45/1,00,000 /year

**Pathology and pathogenesis**

*M. bovis* infection arises from drinking non-sterilized milk from infected cows;

*M. tuberculosis* is spread by the inhalation of aerosolized droplet nuclei from other infected patients.

The smallest particles (1-5 μm) enter the periphery of the lung and are engulfed

by macrophages

CD4+ T lymphocytes produce an array of cytokines, including interferon-gamma (IFN-γ)

recruitment of monocytes formation of granulomas limiting the replication and

spread of the organism appearance of the primary lesion in the lung ('Ghon focus')

The combination of a primary lesion and regional lymph node involvement is

termed the 'Ghon complex'.

**Secondary tuberculosis:**

**Cause:**The bacilli spread (either by lymph or blood) before immunity is established, secondary foci may be established in other organs

**Site:**

* lymph nodes,
* serous membranes,
* meninges ,
* bones,
* liver,
* kidneys
* lungs

**FACTORS INCREASING THE RISK OF TB**

* Age (children > young adults < elderly)
* First-generation immigrants from high-prevalence countries
* Close contacts of patients with smear-positive pulmonary tuberculosis
* Overcrowding: prisons, collective dormitories
* Chest radiographic evidence of self-healed tuberculosis
* Primary infection < 1 year previously
* Immunosuppression-HIV, infliximab, high-dose corticosteroids, cytotoxic agents
* Malignancy (especially lymphoma and leukaemia)
* Type 1 diabetes mellitus
* Chronic renal failure
* Silicosis
* Gastrointestinal disease associated with malnutrition

**PRIMARY TUBERCULOSIS**

**Cause:**

Primary TB refers to the infection of a previously uninfected (tuberculin-negative) individual. A few patients develop a self-limiting febrile illness but clinical disease only occurs if there is a hypersensitivity reaction or progressive infection

**CLINICAL PRESENTATIONS OF PRIMARY PULMONARY TB**

* Chronic cough, often with haemoptysis
* Pyrexia of unknown origin
* Unresolved pneumonia
* Exudative pleural effusion
* Asymptomatic (diagnosis on chest X-ray)
* Weight loss, general debility
* Spontaneous pneumothorax

**Milliary TB:** Blood-borne dissemination gives rise to milliary TB

**Feature:**

* 2-3 weeks of fever,
* Night sweats,
* Anorexia,
* Weight loss and
* Dry cough.
* Hepatosplenomegaly may be present
* Presence of a headache may indicate co-existent tuberculous meningitis

**CHRONIC COMPLICATIONS OF PULMONARY TB**

**Pulmonary**

* Massive haemoptysis
* Cor pulmonale
* Fibrosis/emphysema
* Atypical mycobacterial infection
* Aspergilloma
* Lung/pleural calcification
* Obstructive airways disease
* Bronchiectasis
* Bronchopleural fistula

**Non-pulmonary**

* Laryngitis
* Enteritis
* Anorectal disease
* Amyloidosis
* Poncet's polyarthritis

**DIAGNOSIS OF TB**

**Specimen**

**Respiratory**

* Sputum\* (induced with nebulised hypertonic saline if not expectorating)
* Gastric washing\* (mainly used for children)
* Bronchoalveolar lavage
* Transbronchial biopsy

**Non-respiratory**

* Fluid examination (cerebrospinal, ascitic, pleural, pericardial, joint)
* Tissue biopsy (from affected site; also bone marrow/liver may be diagnostic in patients with disseminated disease)

**Diagnostic tests**

* Circumstantial (ESR, CRP, anaemia etc.)
* Tuberculin skin test (low sensitivity/specificity; useful only in primary or deep-seated infection)
* Stain
  + Zeihl-Neelsen
  + Auramine fluorescence
* Nucleic acid amplification
* Culture
  + Solid (Löwenstein-Jensen, Middlebrook)
  + Liquid (e.g. BACTEC)
* Response to empirical antituberculous drugs (usually seen after 5-10 days)

**Control and prevention**

**BCG (the Calmette-Guérin bacillus)** is a live attenuated vaccine used to stimulate protective immunity and prevent the dissemination of MTB in an infected host. Vaccination policies vary worldwide according to incidence and health-care resources.

**Multidrug-resistant TB**

Multi-drug resistant tuberculosis (MDR-TB) is defined as resistance to both isoniazid and rifampicin, with or without resistance to any other antitubercular drugs.

**Drug Dose & combination:**

* Rifampin: 150 mg
* Isoniazid: 75 mg
* Ethambutol: 275 mg
* Pyrazinamide: 400 mg
* 2 choice of combination: 4FDC and 2FDC

**MAIN ADVERSE REACTIONS OF FIRST-LINE ANTITUBERCULOUS DRUGS**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Drugs | **Isoniazid** | **Rifampicin** | **Pyrazinamide** | **Streptomycin** | **Ethambutol** |
| **Major adverse reactions** | Peripheral neuropathy1 Hepatitis2 Rash | Febrile reactions Hepatitis Rash Gastrointestinal disturbance | Hepatitis Gastrointestinal disturbance Hyperuricaemia | 8th nerve damage Rash | Retrobulbar neuritis3 Arthralgia |

## 

## Prevention & Control of TB in Bangladesh

**The National TB Control Program (NTP)**

**Goals and objectives of the National TB Control Program ( NTP)**

The overall goal of the NTP is to reduce morbidity, mortality and transmission of TB until the disease is no longer a public health problem.   
The objectives are to detect 70% of new smear-positive pulmonary TB cases and cure at least 85 % of them by the year 2005 and be maintained thereafter to reach the MDG by 2015.

**DOTS Strategy:** The NTP adopted the WHO recommended strategy of Directly Observed Treatment Short-course (DOTS) in 1993.The DOTS strategy consists of five components:

* Political commitment
* Diagnosis by direct microscopy
* Directly Observed Treatment (DOT)
* Uninterrupted supply of drugs
* Standard recording and monitoring of detection and treatment results

**Achievements**

Since the introduction of DOTS the NTP and its partners have achieved satisfactory treatment results in new smear-positive patients, 84% treatment success among the patients detected during 2001. However, case detection has remained under 35%. During 2004 the detection rate of new smear-positive patients was 46%.During 2005 the detection rate of new smear-positive patients was 61% and treatment success rate 89%.

### Conclusion:

The visit to said institute was very much helpful to us. Though for obvious limitation it is very difficult to get a true picture of what part of the total population has been suffering from a life threatening disease like leprosy, but in spite of limited resources the organization has been playing a very important role in controlling and preventing tuberculosis which is appreciable.

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# LEPROSY HOSPITAL, SYLHET

There are two Government leprosy hospitals in Bangladesh, one in Dhaka at Mohakhali and the another one is in Sylhet at Sheikhghat.There is another non-government hospital in Nilfamary. We the 4th year MBBS students(SWMC-III) of Sylhet Women’s Medical College, have visited Sylhet Leprosy Hospital on 11th & 12th March,2011 under the guidance of department of Community Medicine. Sylhet Leprosy Hospital is a specialized hospital in sylhet Sadar at, Kolapara situated 1 kilometer north-east from Sylhet Osmani Medical College Hospital. The hospital was established in the year of 1890 as an asylum with the objective to provide rehabilitative services for leprosy patients. Later in year 1963, it was completely transformed into a specialized leprosy hospital with the purpose of providing diagnostic, curative, prognostic & rehabilitative services. The hospital is a three storied building having outdoor, indoor and diagnostic facilities. The hospital is headed by junior consultant Dr. Jakaria Ahmed.

* Date of visit : 11-03-2011& 12-03-2011.
* Name of organization : Leprosy Hospital, Sylhet
* Location  **:** Sheikhghat, Kolapara, Sylhet
* Year of establishment : 1890 as an asylum for rehabilitation of leprosy patients.

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**Objectives of visiting Leprosy Hospital:**

1. To see the service rendered by Leprosy Hospital.
2. To see the management of leprosy cases and the system they have adopted for different types of leprosy cases.
3. To see some cases of leprosy which are infrequent in general hospitals.
4. Staffing pattern & infrastructure of the hospital.
5. Protective measure of the employee, if any.

**Infrastructure**:

* It stands on 4 acres of land. Besides the main hospital building, there is a mosque and a graveyard.
* The hospital building is three storied building.

**►**Ground floor accommodates office of the hospital-in charge, medical officer, nurse station, outdoor service and pharmacy.

**►**1st floor accommodates male ward.

**►**2nd floor accommodates the female ward.

**►**Number of bed: 80

Bed occupied on the day of visit: 41

●Patients of hospital in last one year: in indoor, 83 patients were admitted and outdoor patients were 2000

**Activities of organization:**

1. Diagnosis of patients with active infections thus promotion of early detection of leprosy cases.
2. To ensure effective chemotherapy to all patients free of cost.
3. To provide training programs.
4. Supervision of drug delivery center.
5. Prevention of disability and Support the patient psychologically.

**Organization Staffing**

|  |  |
| --- | --- |
| **Name of the post** | **Number of post** |
| Senior consultant | 1 |
| Medical officer | 2 |
| Stuff nurse | 7 |
| Medical Technician | 1 |
| Assistant | 2 |
| MLSS | 4 |
| Aya | 4 |
| Electrician | 1 |

### Personal observation:

On visit my observation are as follows-

1. It is 80-bedded hospital but all beds are occupied with patients.
2. Cleanness of hospital is average.
3. Working environment is satisfactory.
4. Lack of manpower.
5. Special shoes are supplied for the patients.

**Disease review**: **LEPROSY**

**♦Epidemiology:**

Some 4 Million people have or are disabled by leprosy. World-wide active transmission continues, with around 750000 new cases detected annually, many of them children. About 70% of the world’s leprosy patients live in India, Bangladesh, with Brazil, Indonesia, Mozambique, Madagascar, Tanzania and Nepal being the most endemic countries. Age, sex and household contact are important determinants of leprosy risk; leprosy risk reaches peak at 10-14 years, and an excess of male cases has regularly been found. HIV infection is not a risk factor for leprosy.

In Bangladesh, at present, -Incidence rate: 1/1000

-Prevalence rate: about 1/1000, previously was 12.5

Incidence rate is more in Tangail, Rajshahi, Shirajgonj, Rongpur, Jamalpur, Natore, Mymensingh in Bangladesh.

**♦Pathology and pathogenesis:**

An acid-fast bacillus **Mycobacterium Leprae** causes leprosy.

M. Leprae has a predilection for Schwann cells and skin macrophages, and the host response is critical in determination of the outcome of infection. There are three important aspects of leprosy pathogenesis: the spectrum of immune response, nerve damage and immune-mediated reactions.

The organism replicates intracellularly, typically within skin histiocytes, endothelial cells and the Schwann cells of nerves.

There are two forms:

* 1. ***Tuberculoid Leprosy:*** also called paucibacillary leprosy as the skin lesions contains few bacilli. Here the cell-mediated immunity to the organism limits its growth, and also causes nerve damage. The cell-mediated immune response includes CD4+ Helper T cells & Interferon-γ, IL-2 and IL-12.

Lepromin skin test result is positive.

* 1. ***Lepromatous Leprosy***: Also called multibacillary leprosy as the skin lesion contains have large number of bacilli. Here cell-mediated immunity is poor. Foamy Histiocytes rather than granulomas are found.

Lepromin skin test result is negative.

## ♦FACTORS INCREASING THE RISK OF LEPROSY

* Low Socio-economic condition
* Malnutrition
* Immunocompromised person
* Chronic debilitating illness
* Age
* Sex
* First-generation immigrants from high-prevalence countries
* Close contacts of patients with patients of Lepromatous leprosy, who discharge Leprosy Bacilli in large number in nasal secretions & from skin lesions.

**♦Clinical features:**

Onset is insidious. First sign of leprosy is a non-specific or indeterminate skin lesion that often heals spontaneously. This occurs in the body skin, ear lobes, superficial nerves, nose, eyes & testicles.

1. Skin lesions**:** Anesthetic macular & erythematous lesions, nodules & diffuse skin infiltration.
2. Nerve involvement:Thickening due to infiltration, neuritis, anesthesia, paraesthesia, trophic ulcers, shortening of digits due to bone resorption.
3. In Lepromatous Leprosy, diffuse symmetrical thickening of the skin cause thickened brows & ear lobes producing lion-like (Leonine) facies.
4. Eye involvement is common

.

**♦Complication:**

**1)**The skin anesthesia results in burns and traumas that often become infected.

**2)**Resorption of bone leads to loss of features like nose, fingertips.

**3)**Amyloidosis may occur late in Lepromatous Leprosy.

## 

## ♦ LABORATORY DIAGNOSIS

**Specimen:** Scraping from the mucosa of anterior part of the nasal septa and the edges of the ear lobes.

**Staining:** Smears are stained by modified Zeihl-Neelsen staining method. Lepra bacilli are mainly intracellular within macrophages.

**Biopsy:**of skin or of the thickened nerve gives typical histological features.

**Lepromin skin test:**Lepromin, an extract of Lepromatous tissue is the antigen. It is injected intradermally & induration is observed 48 hours later. In positive cases, induration indicates existence of cell-mediated immunity against Lepra bacilli. It gives a type-IV Hypersensitivity reaction.

It is positive in Tuberculoid Leprosy, and is negative in Lepromatous Leprosy.

**♦Drug Treatment:**

|  |  |  |  |
| --- | --- | --- | --- |
| Modified WHO-Recommended multi-drug therapy regimens for leprosy | | | |
| Type of leprosy\* | Monthly supervised drug treatment | Daily self-administered drug treatment | Duration of drug treatment |
| Paucibacillary | Rifampicin 600 mg | Dapsone 100 mg | 6 months |
| Multibacillary | Rifampicin 600 mg  Clofazimine 300 mg | Clofazimine 50 mg  Dapsone 100 mg | 12 months |
| Paucibacillary single lesion | Ofloxacin 400 mg  Rifampicin 600 mg  Minocycline 100 mg |  | Single dose |
| \*WHO classification for field use when slit skin smears are not available:   * Paucibacillary single-lesion leprosy (one skin lesion) * Paucibacillary (2-5 skin lesions) * Multibacillary (more than 5 skin lesions)   In this field classification WHO recommends treatment of Multibacillary patients for 12 months only. | | | |

♦Main adverse reaction of the drugs

|  |  |  |
| --- | --- | --- |
| Drugs | **Rifampicin** | **Dapsone** |
| **Major adverse reactions** | Febrile reactions Hepatitis Rash Gastrointestinal disturbance | Haemolysis  High coloured urine  Methaemoglobinemia  Peripheral neuropathy |

♦ Prognosis

The majority of patients, especially those who have no nerve damage at the time of diagnosis, do well on MDT, with resolution of skin lesions. Borderline patients are at risk of developing type 1 reactions which may result in devastating nerve damage.

**♦Control and prevention:**

The previous strategy of vertical leprosy campaigns has now been superseded by integrated programmes with primary health care workers in many countries now responsible for case detection and providing Multi-Drug Therapy (MDT).

BCG vaccination has been shown good but variable protection against leprosy; adding killed *M. Leprae* to BCG does not give enhanced protection.

### Conclusion:

### This field visit was carried on as a part of our curriculum. The visit to said institute was very much helpful to us. Though for obvious limitation it is very difficult to get a true picture of what part of the total population has been suffering from a life threatening disease like leprosy, but in spite of limited resources the organization has been playing a very important role in controlling and preventing leprosy which is appreciable. The visit to said institute was very much helpful to us. After this visit we got clear conception about control, prevention and treatment of leprosy, which will be helpful in future in our practice of medicine.

# JALALABAD DISABLED REHABILITATION CENTRE & HOSPITAL, SYLHET.

Bangladesh is the most densely populated country with a population of about 150 million of which 75% live in the villages. Besides other characteristics of the developing countries of health sector of Bangladesh also lacks proper and modern facilities. It is estimated by WHO that about 10% of population suffer from physical and mental disability resulting from various disease and accidents. Most often this huge population cannot afford to avail medical treatment and rehabilitation facilities. So far rehabilitation services are concerned facilities very limited as there is only one centre in Dhaka at Savar. Jalalabad Disabled Rehabilitation Centre & Hospital, Sylhet is the only one functioning rehabilitation centre which plays very vital role for the disabled.

We the 4th year MBBS students (SWMC-V) of Sylhet Women’s Medical College, have visited Jalalabad Disabled Rehabilitation Centre & Hospital, Sylhet Group wise on 9th, 10th & 11th March, 2013 under the guidance of department of Community Medicine. Jalalabad Disabled Rehabilitation Centre & Hospital is a specialized hospital in sylhet Sadar at Kumarpara opposite to Hazrat Manik Pir Saheb (Rahmatulla – he Alaihe) graveyard. The hospital was established in the year of 1996 with a small outpatient clinic rental tin shed house for helping the physically challenged underprivileged people of all ages. It has been a time demanding, brilliant effort from the Rotary Club of Jalalabad under Rotary International District 3280, Bangladesh. With whole hearted effort from the authority subsequently has grown in few years time into a big, full fledged specialized hospital in its own multistoried building. It serves total services to the disabled headed by Dr. Saydur Rahman.

* Date of visit : 9, 10, 11 March 2013
* Name of organization : Jalalabad Disabled Rehabilitation Centre & Hospital
* Location  **:** Kumarpara, Manikpir Saheb Road, Sylhet.
* Year of establishment : 1996

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**Objectives of visiting Jalalabad Disabled Rehabilitation Centre & Hospital:**

1. To observe the services rendered by Jalalabad Disabled Rehabilitation Centre & Hospital
2. To gain practical knowledge regarding rehabilitation services provided to the disabled persons.
3. To see some cases of disabled person and their management as these services are not provided by general hospitals in full.
4. Infrastructure, Machines & equipments, Staffing pattern of a rehabilitation centre for the disabled.

**Aims & Objectives**

* To utilize existing capacity of handicapped patient up to optimum level
* To conduct physio and occupational training courses of various duration & grades in order to develop skilled men power.
* To set up linkage with international and national communities.

**Board of Management:**

1. Chairman – 01
2. Vice-chairman – 01
3. Secretary - 01
4. Additional Secretary – 01
5. Directors – 13

**Employees:**

|  |  |  |
| --- | --- | --- |
| **Sl. No.** | **Post** | **Number** |
| 1 | Senior Consultant Neurology | 1 |
| 2 | Consultant Physiotherapist (Rehab.) | 2 |
| 3 | Occupational Physiotherapist | 1 |
| 4 | Clinical Physiotherapist | 1 |
| 5 | Medical Officer | 3 |
| 6 | Physiotherapy Technologist | 3 |
| 7 | Physiotherapy Assistant | 11 |
| 8 | Nurses | 5 |
| 9 | Receptionist | 3 |
| 10 | Manager | 1 |
| 11 | Care taker | 1 |
| 12 | Ward Assistant | 8 |
| 13 | Aya | 4 |
| 14 | Guard | 2 |
| **Limb Centre** | | |
| 15 | Chief Technologist of Limb & Breech | 1 |
| 16 | Assistant technologist Limb & Breech | 3 |
| **Total** |  | **50** |

**Available Services:**

**Outdoor Service:**

* Number of Doctors: 03
* Average daily Patients: 100
* Days: Saturday - Thursday
* Time : 9.00am – 5.00pm
* Fee : 30 taka

**Indoor Services:**

* Number of bed: 33

( Cabin – 16,

Ward (17)– Male: 8, Female & Paediatrics – 9

**Charge:**

**Cabin : 300 – 400 Taka**

**Ward Bed: 150 taka**

**Free for patients certified as poor by the concerned Ward Commissioner / Chairman**

●Number of patients taken services from the hospital in the last year (2012:

**Workshop**: Following instruments are made for external support of patients

* Ankle foot orthosis
* Cock up splint
* Elbow splint
* Finger splint
* Tailor brace
* Weight bag

**One Male Exercise therapeutic Unit: Charge 150 tk but free for poor**

|  |  |
| --- | --- |
| **Instrument** | **Number** |
| Static Bicycle | 1 |
| Walker | 1 |
| Bed | 4 |
| Shoulder Wheel | 1 |

**One Female Exercise therapeutic Unit: Charge 150 tk but free for poor**

|  |  |
| --- | --- |
| **Instrument** | **Number** |
| Ball | 1 |
| Walker | 1 |
| Special Chair for Child | 1 |
| Bed | 3 |

**Available Instruments**

|  |  |  |
| --- | --- | --- |
| **Sl. No.** | **Name** | **Number** |
| 1 | Short wave diathermy | 1 |
| 2 | Micro computed traction unit | 3 |
| 3 | Ultrasound Unit | 2 |
| 4 | Electrical Stimulator | 2 |
| 5 | Paraffin Wax | 1 |
| 6 | Tranceelectrica nerve stimulator | 2 |

**Common Cases:**

* 1. Neurologic Case

Stroke

Cerebral Palsy

Spinal Cord Injury

Bell’s Palsy

* 1. Orthopaedic Cases

Frozen shoulder

Osteoarthritis

Intervertebral disc prolapsed

**Special Facilities**

* Doctors are available round clock – 24 hours a day.
* Generator Service is available
* Kitchen Facilities

**Limitation:**

* Inadequate Accommodation
* Insufficient Fund
* Lack of Ambulance Service
* Lack of Children exercise therapeutic unit

**Future Plan**

* Establishment of another large rehabilitation hospital within 10 km of City .
* Establishment of Blood Bank, Limb Centre

**Conclusion:**

Jalalabad Disabled Rehabilitation Centre is an achievement of Rotary Club of Jalalabad. They render service for humanity through treatment and rehabilitation. We believe that such landmark of charitable project will inspire us to do something for mankind in our future life.